IDAHO IMMUNIZATION PROGRAM
PROVIDER ENROLLMENT AGREEMENT
July 2011

Medical/Agency Director: _____
(Authorized to sign for practice/agency) Last First MI

Medical/Agency Director Email Address: _____ @ _____

Clinic/Practice/Agency: _____ VFC Pin #: _____

Mailing Address: _____
Street City State Zip

To receive vaccines through the Idaho Immunization Program, which includes the federal Vaccines for Children (VFC) Program, and to receive federal and state procured vaccine at no cost, I, on behalf of myself and all practitioners for whom I am the medical/agency director or equivalent, agree to the following:

1. I will screen all patients 0-18 years of age to determine eligibility for the VFC program during each visit vaccines are administered. I will administer non-universal (VFC-only) vaccines to children 0-18 years of age who meet one or more of the following categories:
    a. Is an American Indian or Alaska Native,
    b. Is enrolled in Medicaid,
    c. Has no health insurance,
    d. Is underinsured. Underinsured children have private health insurance but the coverage does not include vaccines; the coverage includes only selected vaccines (VFC eligible for non-covered vaccines); or, children whose insurance caps vaccine coverage at a certain amount (once the coverage amount is reached, these children are categorized as underinsured). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or other clinic that has a signed Delegation of Authority.

2. If my clinic has not signed a Delegation of Authority, I will not administer state-supplied VFC-only vaccine to underinsured children and I will inform parents or guardians of underinsured children that free vaccine may be available at a FQHC, RHC, or other provider with a signed Delegation of Authority.

3. I will retain all records related to the VFC program for a minimum of three years. If requested, these records and patient immunization records will be made available to the Idaho Immunization Program and/or the Department of Health and Human Services.

4. I will permit visits to my facility by authorized representatives of the Idaho Immunization Program or Department of Health & Human Services to review compliance with the Idaho Immunization Program Policies and Guidelines, to include, but not limited to: patient chart review, vaccine handling & storage, administration techniques, and other applicable immunization subjects. Release of such records will be bound by the privacy protection of the federal Medicaid law and falls within the HIPAA Privacy Rules 45 CFR § 164.512(b).

5. I will comply with the immunization schedule, dosage, and contraindications that are established by the ACIP and included in the VFC program unless:
    a. In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate.
    b. The particular requirements contradict state law pertaining to religious and other exemptions.

6. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA) and will report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

7. I will not charge more than the CMS Regional Fee Cap of $14.34 per vaccine dose for VFC-eligible non-Medicaid clients. For Medicaid VFC-eligible clients, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

8. I will not impose a charge for state-supplied vaccine.

9. I will not deny administration of any vaccine received from the Idaho Immunization Program to a patient due to the inability of a child's parent, guardian, or individual of record to pay the administration fee.

10. I will complete and submit the Provider Enrollment Agreement and the Provider Profile form within 30 days of receipt.

11. I will comply with the requirements for ordering, vaccine accountability, and vaccine management which include the following:
    a. complete and submit accountability reports, through the Immunization Reminder Information System (IRIS) with each vaccine order submitted.
    b. vaccine received from the Idaho Immunization Program will not be distributed to any other health care provider without prior authorization from the Idaho Immunization Program.
    c. maintain an adequate inventory of Idaho vaccine supply to meet the needs of my eligible patients.
    d. maintain proper storage and handling procedures for vaccine and reimburse/replace for vaccine loss due to negligence.

12. I agree to operate with the Idaho Immunization Program in a manner intended to avoid fraud and abuse.

13. I will enter and/or update each patient's VFC-eligibility or insurance information into IRIS; and I will enter each dose of state supplied vaccine into IRIS within 45 days of administration.

14. I understand that I or the Idaho Immunization Program may terminate this agreement at any time for personal reasons or failure to comply with these requirements. I understand that if this agreement is terminated, I must return to the Idaho Immunization Program all unused (viable and non-viable) vaccine that has been provided by the state. I also will comply with the Idaho Immunization Program's Policies and Guidelines for return of the vaccine.

15. I understand and agree that at all times, the Idaho Immunization Program owns and retains rights to the vaccines until administered to a patient, and that in health emergencies I may have to return vaccines to the Idaho Immunization Program upon the Program's request.

I certify that I have read and agree to the requirements listed above pertaining to participation in the Idaho State Vaccine and the federal Vaccines for Children Program. My facility will participate as a:

- ☐ *Traditional Provider*
- ☐ *Adolescent Provider*
- ☐ *Specialty Provider*

_____ Date _____

Provider Signature (person authorized to sign for practice/clinic/corporation.)

Employer Identification Number (EIN) #:_____

For Medical Directors and Solo Practitioners: Medical License #: _____

Medicaid Provider #:_____

_____ Date: _____

Jane S. Smith, Administrator
Division of Health
Department of Health and Welfare